

Treatment Data System

**a division of the Office of Substance Abuse Data System
OSADS**

INSTRUCTION MANUAL

Office of Substance Abuse
Marquardt Building 3rd Floor
AMHI Complex
#159 State House Station
Augusta, ME 04333-0159

July 2000

Treatment Data System USER MANUAL



Prepared by the Staff of the Office of Substance Abuse

Kimberly Johnson, Director

Jamie Clough, Information Systems Division Manager

Billy Joe Ladd, Treatment Data Specialist

Printed Under Appropriation Number 013 14G 1530 022

TABLE OF CONTENTS

Overview.....	1
Introduction.....	2
TDS - The Treatment Data System.....	3
Correct Form to Use.....	3
Timing And Consequences of Late Data.....	5
When Do You Send in The Completed Forms?.....	5
Where Do You Call If You Have Questions or Need More Forms?.....	6
Part 1 - TDS A-1 Admission Form.....	7
Part 2 - TDS D-1 Discharge Form.....	31
Part 3 - Corrections to The TDS Forms.....	50
Part 4 - 90 Day Case Plan Report.....	52
Part 5 - Follow-up Report.....	54
Appendix A- Attorney General's Opinion.....	56
Appendix B - Urban I, Urban II, And Rural Codes.....	58
Appendix C - Service Definitions	61
Appendix D - Referred Agency Codes.....	65
Appendix E - Federal Identification Codes.....	68
Appendix F - Global Assessment of Functioning (GAF) Scale.....	73

Web Address for OSA
<http://www.state.me.us/bds/osa/>

OVERVIEW

This document provides the details of the Treatment Data System (TDS).

TDS is a comprehensive management information system that lends itself to client **outcome evaluation**. Preliminary studies completed by Maine substance abuse service providers in the mid-1980's showed that approximately 50% of the clients who have received services will **reenter** the substance abuse treatment system. TDS will allow the State to assess client outcomes, costs, etc., related to high and low use populations. The system will also allow us to assess health, economic, etc., outcomes for the clients who will **not** reenter the treatment system. In addition, TDS will be capable of addressing needs and service outcomes as they relate to smaller and **special needs** populations, e.g., the elderly.

To determine if the client benefited from these State-funded services, the State will contract with an outside agency to conduct client follow-up interviews six-months post treatment. Participation in the follow-up is **voluntary**. Participation, or the lack of participation, in the follow-up interview process, will not have any effect upon the client's treatment or the State's willingness to pay for the treatment.

Please remember that this manual is NOT for help submitting the data via the WEB.

INTRODUCTION

The Treatment Data System (TDS) was mandated by the State Legislature in P.L. 1983 c. 464. TDS is a vital management tool, used by the Office of Substance Abuse to provide:

- ? Documentation that clients were served and that services were delivered by community providers supported by state substance abuse funds, in compliance with the legislatively approved budget and statutory mandates.
- ? Data on performance that is being jointly used by state and local management to manage services and funding.

TDS will also be used to meet the federal requirements of the Treatment Episode Data Set (TEDS). TEDS was established by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA) to meet requirements specified in the Anti-Drug Abuse Act of 1988.

It is due to the federal requirements of the TEDS that any agency receiving state funds (including Federal Block Grant) must report all substance abuse clients, regardless of the source of funding for individual clients.

A TDS registry is maintained for all agencies and programs that receive state funds to perform client services under contract with the State Departments (Department of Behavioral and Developmental Services, -formerly known as Department of Mental Health/Mental Retardation and Substance Abuse Services-, Department of Corrections and Department of Human Services).

Client information reported to the OSA through TDS is confidential and protected by law and operating computer safeguards. No person or agency other than authorized personnel can gain access to client information in TDS.

A word about the Manual . . . The purpose of the TDS User Manual is to provide current reporting instructions, special program area reporting instructions, and common TDS item definitions for state and local TDS users. TDS is a complex data system requiring users to maintain a high level of understanding of its procedures. The manual is most readily used as a reference book, although it is recommended that anyone completing TDS forms first read the manual from cover to cover one time. This manual is designed to accommodate the needs of multi-service providers as well as providers of a single-service setting.

All changes in reporting instructions that modify this manual will be communicated to the TDS contact person through numbered and dated TDS Manual Addendum Memoranda from the staff of the Office of Substance Abuse.

TDS - The Treatment Data System

The purpose of TDS is to provide specific admission and discharge data about an individual client stored by TDS under the client code. This data is then available for aggregation within TDS to produce output reports.

TDS Forms:

Three different forms are used in TDS—depending on which service setting the client is using.

- ? A-1 Admission Form
- ? D-1 Discharge Form
- ? A-D Shelter / Detoxification Form

DEFINITION: "SERVICE SETTING" means a distinct type of service or group of services for persons with substance abuse problems, provided in the community under a contract with the three State Departments (Department of Mental Health/Mental Retardation and Substance Abuse Services, Department of Corrections, and the Department of Human Services).

The forms are identified by titles appearing in the top left corners.

Correct Form to Use:

- ? The A-1 Admission Form (blue) is for all initial admissions and readmissions of all clients except shelter and detoxification.
- ? The D-1 Discharge Form (yellow) is for all discharges except shelter and detoxification.
- ? The A-D Shelter and Detoxification Form (pink) is for shelter and detoxification clients. It is also used for Driver Education and Evaluation Programs (DEEP) clients such as the Weekend Intervention Program, SALCE and Youthful Offender Program.

NOTE: The A-D Shelter form is not to be used for DEEP clients who have been referred to an Agency/Provider for an evaluation or treatment

NOTE: Instructions for the A-D form are in a separate manual. To obtain that manual call the TDS office.

Who Should Be Filling Out the TDS Forms?

The counselor having the face-to-face contact with the client should fill out the TDS forms either during the session or soon after.

Which Clients are Admitted to TDS?

If your agency receives any state or federal funds, you must complete the TDS forms on all your agency's substance abuse clients (substance abusers and affected others/co-dependents) if they meet the following criteria:

- ? Has a substance abuse related problem;
- ? Has completed the screening and intake process;
- ? Has been formally admitted for service;
- ? Has his or her own client record; and
- ? Is receiving service;

NOTE: Any agency/provider that is DEEP certified, Medicaid reimbursable, and/or methadone licensed **must** complete a TDS form on all clients receiving those services.

As a rule, a client may not be admitted to more than one substance abuse service setting at a time, whether within the same provider or by two separate providers. For example, an OSA-funded agency has a contract for detoxification and residential rehabilitation services. A client seeking treatment at the agency is in need of both detoxification and residential rehabilitation services. First, the client is admitted to the detoxification service setting and discharged. Upon completion of the detoxification program, the client is then admitted to the residential rehabilitation program.

Which Clients Should be Discharged from TDS?

Clients should be discharged from TDS for the usual reasons, such as a program completed or a client left without program agreement. Clients should be discharged within 30 days of the last date of contact. A case should never remain open as long as 90 days without the client receiving a face-to-face counseling session unless a specific reason (other than non-appearance for scheduled sessions) is noted in the client record.

TDS Reporting Requirements

All contracted substance abuse treatment agencies must report electronically to TDS via the TDS website. The Office of Substance abuse will provide the address, user ID, and password.

DEEP providers, Medicaid reimbursable agencies and methadone-licensed agencies must report to TDS electronically, if submitting more than 100 forms in a year or if the agency has been identified as having a problem with erroneous data. The TDS office has the discretion of deciding which agencies fit the form limit and which agencies have an excessive number of errors. Any provider under the 100-form limit is ENCOURAGED to submit electronically but may submit paper forms.

Timing and Consequences of Late Data

SUBMISSION OF TDS FORMS/DATA FILES IS A CONTRACTUAL/ LICENSURE REQUIREMENT. CONTRACT PAYMENTS WILL NOT BE APPROVED AND LICENSURE/CERTIFICATION MAY BE REVOKED IF TREATMENT PROVIDERS FAIL TO SUBMIT FORMS IN A TIMELY MANNER.

PROGRAMS THAT CONSISTENTLY SUBMIT LATE OR INACCURATE DATA ARE REQUIRED (BY CONTRACT) TO PREPARE A WRITTEN CORRECTIVE ACTION PLAN TO RECTIFY THE SITUATION.

Agency Reported Contact Person

Each agency must have a reported contact person. If the contact person leaves the agency, the TDS office must be notified immediately of the departure of the contact person and the name, address, and telephone number of the new contact person.

System to Identify TDS Client Ids

Each agency and/or provider must maintain a system for readily identifying clients by their TDS client ID's. For examples, please call the TDS office.

When Do You Send in or Enter the Completed Forms?

IF YOUR AGENCY HAS NO ADMISSIONS OR DISCHARGES FOR A GIVEN MONTH, SEND A LETTER NOTIFYING THE TDS OFFICE TO THAT EFFECT.

COMPLETED FORMS MUST BE SENT OR ELECTRONICALLY ENTERED INTO THE SYSTEM NO LATER THAN THE 15TH OF THE MONTH FOLLOWING THE ADMISSION OR DISCHARGE OF THE CLIENT FROM TDS.

Where Should Completed Forms Be Sent?

If you are not using the new Web Based Treatment Data System, mail the OSA copy of completed admission and discharge forms to:

TDS Office
Office of Substance Abuse
Marquardt Building 3rd Floor
AMHI Complex
#159 State House Station
Augusta, Maine 04333-0159

A copy of the TDS form should be retained in the client file
(from multi-part forms retain the ~~A~~Agency Copy@)

Where Do You Call If You Have Questions or Need More Forms?

If you have questions about a data item, if a form has been returned,
or if you need more admission or discharge forms, call:

TDS OFFICE
287-6337
or
e-mail to BillyJoe.Ladd@state.me.us

When you begin running low on forms, call immediately, please do not wait until you are completely out of forms.

PART 1

TDS FORM A-1

ADMISSION FORM

INSTRUCTIONS

DETAILED INSTRUCTIONS

FOR TDS A-1 ADMISSION FORM

DEFINITION OF A TDS CLIENT:

A TDS client is defined as a substance abuser and/or an affected other co-dependent on whom your agency opens an individual client record. Specific client definition criterion includes the following:

- ? Has a substance abuse related problem;
- ? Has completed the screening and intake process;
- ? Has been formally admitted for service;
- ? Has his her own client record; and
- ? Is receiving service.

ALL ITEMS MUST BE COMPLETED. DO NOT LEAVE ANY ITEMS BLANK UNLESS SPECIFIC INSTRUCTIONS ARE GIVEN TO DO SO.

FORMS WILL BE RETURNED IF ITEMS ARE LEFT BLANK.

AGENCY NAME

The name of the agency/provider as **it appears on license or certification.**

? CHANGE/CORRECTION

Place a check in the box ONLY if this form is being filled out as a **change/correction**. If it is a change/correction please go to the change/correction section in your manual for instructions on how to properly complete the form.

AGENCY TELEPHONE NUMBER

Telephone number of the agency- this should be phone number at site of service, not main office.

CLIENT CODE

A. DATE OF BIRTH

Enter the client's birth date. Record MMDDYYYY. Precede numbers of less than ten with a zero.

EXAMPLE: February 9, 1943 would be **02091943**.

B. LAST FOUR SOCIAL SECURITY NUMBERS

Enter the last four numbers of the client's social security number.

EXAMPLE: John Smith's social security number is 005-23-9789.
You would enter **9789**.

NOTE: If the client does not have a social security number then use **9999**. **9999** should only be used after you have exhausted all means available to you to obtain their social security number – including billing information.

C. GENDER (check ONE box only)

- ? 01 Male
? 02 Female

D. COUNTY OF RESIDENCE

Enter the first and last letter of the County the client is residing in at admission. If "Out-of-State" use **OS**. If "Out-of-Country" use **OC**.

AN	Androscoggin	PT	Penobscot
AK	Aroostook	PS	Piscataquis
CD	Cumberland	SC	Sagadahoc
FN	Franklin	ST	Somerset
HK	Hancock	WO	Waldo
KC	Kennebec	WN	Washington
KX	Knox	YK	York
LN	Lincoln	OS	Out-of-State
OD	Oxford	OC	Out-of-Country

E. **HOME TOWN/CITY (check ONE box only)**

Size of home town/city at time of admission.

? 01 **URBAN I:** A town/city of more than 10,000

? 02 **URBAN II:** A town/city of 5,000 - 9,999

? 03 **RURAL:** A town of less than 5,000

? 04 **OS/OC:** Out-of-State, Out-of-Country (Required if D. was OS or

OC)

See Appendix B for the listing of Urban I, Urban II, and Rural areas.

F. **FEDERAL IDENTIFIER CODE**

A six digit numeric code provided by the federal government to the OSA. The code identifies the agency by physical location. If you do not have a federal identifier code listed in the appendices, please contact the TDS office as soon as possible.

Federal identifier codes are listed in Appendix E.

G. **CONTRACT NUMBER (Funded Agencies ONLY)**

If agency/provider has a contract with The Office of Substance Abuse and OSA will be one of the payor sources, enter the contract number assigned, otherwise leave blank. (If OSA is not an expected payor source, you do not need to enter the number.) This number may not fill all spaces available.

H. **PRIMARY SERVICE CODE (List on Back of form)**

Enter the code of the service being provided for this client.

This is the primary service you will provide for this client during the current admission.

See specific explanations of primary service setting codes in Appendix C.

✍ **All** agencies should use co-existing mental illness service settings for clients who have a co-existing mental illness. (MH/MR question is # 28)

✍ **All** agencies delivering outpatient services should use 18 Adolescent Outpatient for all clients who are under 19 years of age, at the time of admission, who are receiving **non-intensive** outpatient services.

Next Page

Substance Abuse / Affected Clients

**Substance Abuse
Clients with Coexisting Mental Illness**

REHABILITATION / RESIDENTIAL

03 **Hospital** (Other than Detoxification)
04 **Short-term** (30 days or less)
05 **Extended Care**
06 **Halfway House**
07 **Extended Shelter**
15 **Adolescent Res.Rehab.Trans.**
44 **Consumer Run Residence**

23 **Hospital** (Other than
detoxification)
24 **Short-term** (30 days or less)
25 **Extended Care**
26 **Halfway House**
27 **Extended Shelter**
28 **Adolescent Res.Rehab.Trans.**
45 **Consumer Run Residence**

AMBULATORY

08 **Non-Intensive Outpatient**
11 **Intensive Outpatient**
12 **Detoxification**
13 **Evaluation**
18 **Adolescent Outpatient**
38 **Adolescent Intensive Outpatient**
40 **Methadone**

29 **Non-Intensive Outpatient**
32 **Intensive Outpatient**
33 **Detoxification**
34 **Evaluation**
35 **Adolescent Outpatient**
39 **Adolescent Intensive
Outpatient**

Each is listed on the backs of the forms.

I. CURRENT ADMISSION DATE

The day the client is currently being admitted into treatment.

Record MMDDYYYY. Precede numbers of less than ten with a zero.

EXAMPLE: September 1, 1996 would be **09011996**.

K. PAYOR CODE (check ONE box only)

Check the appropriate payor code for the client. The payor code is based on the primary payor of services. If OSA is the primary payor of the client's services, check **01 OSA**.

NOTE: If your agency does not have a contract with OSA you cannot check 01.

- ? 01 **OSA/BDS** - Office of Substance Abuse Clients
- ? 02 **Human Services** - Adult, Child Protective, Medicaid (**NOT** SSI related)
- ? 03 **Corrections** - Probation Parole, Correctional Facilities
- ? 99 **Other** - Not funded by a state agency (this would include DEEP, self-pay and health insurance)

1. REFERRAL (List on Back of form)

Enter the primary self-reported source of the referral from the following list of codes (also listed on the back of the TDS Form). This is the responsible source for the client seeking services. **NOTE:** If you are filling out DEEP paperwork, report client as DEEP referred.

If the referring person is a staff person working at an alcohol/drug abuse service agency, please record this as "substance abuse agency."

Note the distinction made between alcohol/drug abuse professionals (e.g., physicians who specialize in alcohol/drug abuse and registered substance abuse counselors) and physicians and other professionals who are not alcohol/drug abuse specialists.

- 01 – **Self**
- 02 – **Family Member**
- 03 – **Employer**
- 04 – **Substance Abuse Professional (Private Practice)**
- 05 – **Substance Abuse Agency**
- 06 – **Physician (Non-substance abuse specialist)**
- 07 – **Other Professional (Non-substance abuse specialist)**
- 08 – **DEEP (Driver Education and Evaluation Program)**
- 09 – **Adult Protective Services - DHS**
- 10 – **Child Protective Services - DHS**
- 11 – **Substitute Care Services - DHS**
- 12 – **Probation/Parole - State of Maine**
- 13 – **Correctional Facility, Maine**

Continued on next page

- 14 - **County Jails**
- 15 - **Augusta/Bangor Mental Health Institute**
- 16 - **Mental Health Agency**
- 17 - **Friend**
- 18 - **EAP**
- 19 - **SAP**
- 20 - **State/Federal Court**
- 21 - **Formal Adjudication Process**
- 22 - **Self-Help Group**
- 23 - **Hospital**
- 24 - **School**
- 25 - **AIDS Outreach Worker**
- 99 - **Other**

EXAMPLE: John Smith was referred by his physician that was treating him for high blood pressure. Enter **06** Physician (non-substance abuse specialist).

2. **PRIOR TREATMENT EPISODES** (check ONE box only)

Check the appropriate number of prior treatment for Substance Abuse in any drug or alcohol treatment program.

- | | |
|---|------------------------------------|
| <input type="checkbox"/> 00 None | No previous treatment episodes. |
| <input type="checkbox"/> 01 One | One previous treatment episode. |
| <input type="checkbox"/> 02 Two | Two previous treatment episodes. |
| <input type="checkbox"/> 03 Three | Three previous treatment episodes. |
| <input type="checkbox"/> 04 Four | Four previous treatment episodes. |
| <input type="checkbox"/> 05 Five or More | Five or more previous episodes. |

3. **ARE SPECIAL ACCOMMODATIONS NEEDED TO PROVIDE SERVICES?**
(check YES or NO for each selection)

- | Yes | No | |
|-----------------------------|-----------------------------|--|
| <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | (A) Hearing Client is hearing impaired. |
| <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | (B) Visual Client is visually impaired. |
| <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | (C) Physical Client is physically impaired. |
| <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | (D) Language Client's primary language is other than English. |
| <input type="checkbox"/> 01 | <input type="checkbox"/> 02 | (E) Other |

EXAMPLE: Sign, TTY, Assistive listening devices, Interpreter, etc.

4. **RACE** (check ONE box only)

Check the appropriate self-reported ethnic background. (If a client refuses, the form preparer must check the race code most appropriate).

? 01 **White**

NOTE: *White.* A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

? 02 **Black or African American**

NOTE: *Black or African American.* A person having origins in any of the racial groups of Africa. Terms such as **AHaitian@** or **ANegro@** can be used in addition to **ABlack or African American.@**

?

? 03 **American Indian or Alaska Native**

NOTE: *American Indian or Alaska Native.* A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

?

? 04 **Asian**

NOTE: *Asian.* A person having origins in any of the original peoples of the Far East, Southeast, Asia, or the Indian subcontinents including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

?

? 05 **Native Hawaiian or other Pacific Islander**

NOTE: *Native Hawaiian or Pacific Islander.* A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

? 99 **Other**

5. **ETHNICITY** (check ONE box only)

Check the self-reported ethnic background.

? 01 **Not of Hispanic Origin or Latino**

? 02 **Hispanic or Latino**

NOTE: *Hispanic or Latino.* A person of Cuban, Mexican, Puerto Rican, Cuban, South or Central American, or other Spanish culture or origin, regardless of race. The term, **ASpanish origin@** can be used in addition to **AHispanic or Latino.@**

6. **VETERAN** (check ONE box only)

DEFINITION: A veteran is an individual who has served on active duty in the Armed Forces with an honorable discharge.

? 01 **Yes**

? 02 **No**

7. **EDUCATION COMPLETED**

Enter the highest grade in school that the client has completed. For those who have a **GED, enter 12**. Remember that these are grades completed, and are not necessarily the number of years of attendance.

NOTE: **Codes range from 00 (None) to 20**. If more than 20 years have been completed, enter 20. Complete both boxes, using a leading zero if necessary (i.e., 01, 02 and so forth).

8. **CURRENT MARITAL STATUS** (check ONE box only)

Check the client's self-reported current marital status on the day of admission.

? 01 - **Never married** refers to a client who has never been married.

? 02 - **Now married/Cohabiting** the client must be living with a spouse/significant other.

? 03 - **Separated** refers to a client and spouse still married but not living together. It does not refer to temporary separation due to employment, military service, or any similar type of separation.

? 04 - **Divorced** refers to an individual who is divorced.

? 05 - **Widowed** refers to an individual whose spouse is deceased.

9-13. **DEPENDENTS**

**ENTER THE NUMBER OF DEPENDENT CHILDREN THE CLIENT
HAS IN EACH AGE GROUP LISTED**

A client has a dependent child(ren) if the client either has custody (joint or full) of the child(ren); or, is in the process of trying to get custody of the child(ren) from another entity whether that is an ex-spouse, ex-partner, grandparent, Child Protection, the State, etc. If the client **does not have** dependent children please **draw lines through the boxes or enter 00.**

- 9. **0 TO 12 months**. Number of dependent children that are 0 to 12 months.
- 10. **13 TO 35 months**. Number of dependent children that are 13 to 35 months.
- 11. **3 TO 5 years**. Number of dependent children that are 3 to 5 years.
- 12. **6 TO 12 years**. Number of dependent children that are 6 to 12 years.
- 13. **13 TO 17 years**. Number of dependent children that are 13 to 17 years.

If No dependents or not custody, skip # 14 and go to item #15.

**14. IF THE CLIENT HAS LEGAL CUSTODY OF HIS/HER CHILDREN,
WHERE ARE THE CLIENT-S CHILDREN WHILE THE CLIENT IS IN
TREATMENT? (check ONE box only)**

- ? 01 **With the client**
- ? 02 **Spouse/other parent**
- ? 03 **Grandparents or other relatives**
- ? 04 **Friend(s)**
- ? 05 **Babysitter/care giver**
- ? 06 **Temporary foster care**
- ? 99 **Other**

15. PREGNANT AT ADMISSION (check ONE box only)

If the client is female, is she pregnant?

Pregnancy should have already been substantiated by a pharmacy home pregnancy test or by a doctor.

NOTE: Check NO for all males.

- ? 01 **Yes**
- ? 02 **No**

If Not pregnant, skip # 16 and go to question #17.

16. IF PREGNANT, IS CLIENT RECEIVING PRENATAL CARE?
(check ONE box only)

If client is pregnant, is she receiving regular prenatal care check-ups with her physician?

? 01 **Yes**

? 02 **No**

17. LIVING ARRANGEMENTS AT ADMISSION (check ONE box only)

Check the self-reported living arrangements at the time of admission.

? 01 **Independent Living, Alone** - an unsupervised living environment.

? 02 **Independent Living, With Others** - living with friends, family, or

?

? 03 **Dependent Living** - a supervised living environment (e.g., boarding home for mentally retarded, correctional facility).

?

? 04 **Homeless** - sleeping in places not meant for human habitation, such as cars, parks, sidewalks and abandoned buildings; also, emergency shelters or are from a transitional or supportive housing for homeless persons who originally came from streets or emergency shelters. This includes persons who ordinarily sleep in one of the above places but are spending a short time (30 consecutive days or less) in a hospital or other institution.

NOTE: A minor child (17 or under) in most cases would be dependent living.

An adult child (18 and over) in most cases would be independent living unless requiring other than "normal" care.

18. **EMPLOYMENT STATUS** (check ONE box only)

Check the self-reported current employment status at the time of admission.
Employment refers to work in a paid (salary, wages, tips, etc.) position on a regular basis.

?

? 01 **Full Time** (35 hours or more)

- A. A client who is working for pay at admission and normally works at least 35 hours per week. This includes those who work at part-time jobs that total at least 35 hours per week; or
- B. Those persons temporarily absent from their regular jobs because of illness, vacation, industrial disputes (strikes), or similar reasons.

? 02 **Part Time** (17-34 hours)

- A. A client who is working for pay at admission and normally works at least 17 hours but not more than 34 hours per week.

? 03 **Irregular** (Less than 17 hours)

- A. A client who is working for pay at admission and normally works fewer than 17 hours per week.

? 04 **Unemployed (has sought work)**

- A. A client who was not working at admission but had sought work and was available within the preceding 30 days.
- B. A client who was not working at admission, but was not working because they were on layoff, temporarily ill or waiting to start new jobs within the next 30 days.

? 05 **Unemployed (has not sought work)**

- A. A client who is discouraged from seeking work because of personal or job market factors, and voluntarily idle.

Continued on next page

? 06 **Not in Labor Force**

This refers to clients who are:

- A. Retired; or
- B. Engaged in their own housekeeping, not working while attending school (including adolescents), unable to work because of long-term illness.

THESE NEXT THREE CATEGORIES ARE DESIGNED FOR CLIENTS WHO ARE NOT CAPABLE OF HOLDING A PAYING POSITION SUCH AS DUAL DIAGNOSIS, LATE STAGE ALCOHOLICS, ETC.

? 07 **Full Time Volunteer**

- A. A client who volunteers at least 35 hours a week and does not receive monetary compensation for those hours.

? 08 **Part Time Volunteer**

- A. A client who volunteers at least 17 hours but not more than 34 hours a week and who does not receive monetary compensation for those hours.

? 09 **Irregular Volunteer**

- A. A client who volunteers less than 17 hours a week and does not receive monetary compensation for those hours.

19. **EMPLOYABILITY FACTOR (check ONE box only)**

Check the appropriate factor listed as it relates to the Employment Status.

- ? 01 **Employable or working now**
- ? 02 **Student**
- ? 03 **Homemaker**
- ? 04 **Retired**
- ? 05 **Unable (to work) for physical or psychological reasons**
- ? 06 **Inmate of Institution**
- ? 07 **Seasonal Worker**
- ? 08 **Temporary Layoff**
- ? 09 **Unable due to skills/resources** (i.e. lack of training, interviewing skills, transportation, child care, etc.)
- ? 10 **Unable due to program requirements** (i.e. Halfway house clients are not allowed to seek employment during part of their treatment)

20. **HOUSEHOLD INCOME (LAST 30 DAYS)**

Enter the amount between **0003-9998** for the client's estimated income for the last 30 days of all individuals living in the household. Household is defined as a group of friends and/or relatives living together as a social group and supporting unit. It does not include hotels, treatment facilities, institutions, etc.

- 0001 - Refused.**
- 0002 - Unknown.**
- 9999 - More than \$9999.**

NOTE: If a client says he or she has absolutely no income enter **0000**.
If the client is a foster child enter **0002** unknown.

YOU MUST NOT LEAVE THIS FIELD BLANK.

EXAMPLE 1: John Smith earns \$150.00 a week or \$600.00 a month. Enter **0600**.

EXAMPLE 2: John Doe is indigent. He occasionally works for a few days here and there, but he is not sure how much he has earned in the last 30 days.
Enter **0002**.

21. **PRIMARY SOURCE OF HOUSEHOLD INCOME/SUPPORT
(LAST 30 DAYS)**

Enter the code for the primary source of household income/support in the last 30 days.

- | | |
|--|-------------------------------|
| 00 - None | 07 - Disability, Other |
| 01 - Wages/Salary
(Includes commissions
and self employment) | 08 - Town Welfare |
| 02 - Retirement | 09 - Child Support |
| 03 - Alimony | 10 - Unemployment Benefits |
| 04 - Food Stamps | 11 - Social Security |
| 05 - TANF(formerly AFDC) | 12 - Dealing Drugs |
| 06 - SSI | 13 - Worker's Compensation |
| | 99 - Other (i.e. investments) |

NOTE: If you said income 0000 for # 20, then source should be 00. If you entered other than 0000 for # 20, then source should not be 00.

22. **SECONDARY SOURCE OF HOUSEHOLD INCOME/SUPPORT (LAST 30 DAYS) IF DIFFERENT FROM PRIMARY**

Enter the code for the secondary source of household income/support in the last 30 days. If different from the Primary. **DO NOT** enter the same code twice (unless 00)

- | | |
|--|-------------------------------|
| 00 - None | 07 - Disability, Other |
| 01 - Wages/Salary
(Includes commissions
and self employment) | 08 - Town Welfare |
| 02 - Retirement | 09 - Child Support |
| 03 - Alimony | 10 - Unemployment Benefits |
| 04 - Food Stamps | 11 - Social Security |
| 05 - TANF(formerly AFDC) | 12 - Dealing Drugs |
| 06 - SSI | 13 - Worker's Compensation |
| | 99 - Other (i.e. investments) |

22. **IS THE CLIENT A VICTIM OF DOMESTIC VIOLENCE?
(check ONE box only)**

Answer **Yes** if the client has sought shelter, required medical attention, called police, or had the police called on his/her behalf because of a domestic violence incident. However, if you, as the clinician, feels that the client is a victim of domestic violence and none of these scenarios have taken place, still answer **Yes**.

- ? 01 Yes
? 02 No

24-27. TREATED FOR MEDICAL REASONS AT THE FOLLOWING LOCATIONS

Enter the number of times the client has been treated at **each** of the following locations.

- 24. Physician's Office/Clinic (in last 12 months)**
- 25. Hospital Emergency Room (in last 12 months)**
- 26. Hospital Inpatient (in last 12 months)**
- 27. Other (in last 12 months)**

EXAMPLE: John Smith is being treated by a physician. He has had monthly appointments for the last six months. Next to # 24-Physician's Office-you would enter **06**.

28. MH/MR ISSUES: DIAGNOSIS BASED ON DSM-IV (check ONE box only)

If the client has been diagnosed with a mental illness/disorder or mental retardation based on DSM-IV criteria, check 01 or 02, otherwise check 00.

Diagnosis Based on DSM-IV – Please remember this question affects H.

- ? **01 Diagnosed Mental Illness/Disorder**
- ? **02 Mental Retardation**
- ? **00 None**

29-30. TREATED FOR MENTAL HEALTH ISSUES AT THE FOLLOWING LOCATIONS.

Enter the number of times the client has been **admitted** for treatment to each of the following locations.

- ? **29. Outpatient Mental Health Services (last 12 months)**
- ? **30. Psychiatric Admission to a Hospital (last 2 years)** *Episodes not visits/sessions*

EXAMPLE: John Smith had a nervous breakdown six months ago and was hospitalized at JBI until stabilized. After leaving JBI he went to weekly outpatient counseling for his mental health issues. Next to **29** Outpatient Mental Health Services you would enter **01**. Next to **30** you would enter **01**.

31. **CONSENT DECREE JANUARY 1, 1989 (check ONE box only)**

Was the client a patient at the Augusta Mental Health Institute on January 1, 1989 or after.

? 01 **Yes**

? 02 **No**

32. **PRIMARY PRESENTING PROBLEM (check ONE box only)**

Check the one major condition that led to the client asking for your service.

? 01 **Substance Use/Abuse**

? 02 **Affected/Co-Dependent**

? 03 **Evaluation Only**

**NOTE: IF AFFECTED/CO – DEPENDENT (02), ANSWER TOBACCO
RELATED QUESTION 36, AND QUESTIONS 40, 44 +48)
THEN SKIP TO QUESTION #51**

33-36. **DRUGS USED INAPPROPRIATELY OR ABUSED BY CLIENT THAT LED
TO ADMISSION PRIMARY, SECONDARY AND TERTIARY**

INSTRUCTIONS: From the following codes (also listed on the back of the TDS form), identify and enter the substance(s) which causes the client's dysfunction at the time of admission.

If the client is a poly drug abuser rank the substances as primary, secondary and if necessary, tertiary.

Clinical judgment will ultimately determine the ranking of problem substances. In determining the degree of substance abuse, the following considerations should be made:

? Client's identified substance of choice;

? Patterns of substance involvement;

? Degree of present or past physical, mental, or social dysfunction caused by substance involvement; and

? Degree of present or past physical or psychological dependence on substances, regardless of the frequency of use of a specific substance.

SEE NEXT PAGE

Each client's substance abuse problem(s) is/are to be individually assessed.

33. **Primary**

This is the primary substance abuse problem for which the client was admitted to treatment. **THERE CAN BE ONLY ONE PRIMARY PROBLEM.**

EXAMPLE: A poly abuser seeks treatment and reports abuse of both cocaine and alcohol with use of marijuana of at least one to three times a month. Based on the guidelines outlined above, the clinician determines that cocaine is the primary problem. Therefore, in Item 33, (code **03**) Cocaine is recorded as the primary problem.

34. **Secondary**

Record a secondary problem only if a primary problem has been entered. There can be only one secondary problem. If there is no secondary problem enter **00** None. Using the example above, Alcohol (code **01**) is recorded as the secondary substance abuse problem.

35. **Tertiary**

Record a tertiary problem only if the primary problem and a secondary problem have been entered. There can be only one tertiary problem. If there is no tertiary problem enter **00** None. Again using the example above and following the ranking guidelines the clinician enters (code **02**) Marijuana for the tertiary substance abuse problems.

NOTE: ***00 (NONE) CANNOT BE ENTERED IN PRIMARY SUBSTANCE FOR A CLIENT WHOSE PRIMARY PRESENTING PROBLEM IS SUBSTANCE ABUSE. YOU MUST ENTER A SUBSTANCE ABUSE CODE.***

NOTE: ***WHEN 00 FOR "NONE" IS ENTERED IN THE SECONDARY OR TERTIARY BLOCKS OF THIS ITEM, ENTER 00 IN THE CORRESPONDING BLOCKS OF ITEMS 34, 35, 38, 39, 42, 43, 46 + 47. If 00 is not entered in the secondary or tertiary blocks, 00 cannot be used in the corresponding blocks.***

36. **Tobacco** (check ONE box only)

? 01 Yes

? 02 No

Was client using a tobacco product at admission?

IF NO ENTER 00 in QUESTIONS 40, 44 AND 48

After all appropriate problem substances have been entered, complete the remaining blocks with zeros. All blocks must be completed.

CODES:

- 00 **None** (FOR USE WITH SECONDARY, TERTIARY AND TOBACCO ONLY).
- 01 **Alcohol.**
- 02 **Marijuana/Hashish:** This includes **THC** and any other Cannabis sativa preparations.
- 03 **Cocaine/Crack.**
- 04 **Heroin.**
- 05 **Non-Rx Methadone :** Methadone obtained and used without a legal prescription.
- 06 **Other Opiates and Synthetics :** Includes codeine, Dilaudid, morphine, Demerol, opium and any other drug with morphine-like effects.
- 07 **PCP:** Phencyclidine..
- 08 **Other Hallucinogens :** Includes Hallucinogens, **LSD, DMS, STP**, mescaline, psilocybin, peyote, etc.
- 09 **Methamphetamines** (speed).
- 10 **Other Amphetamines:** This includes Amphetamines, Benzedrine, Dexedrine, Preludin, Ritalin, and any other amines and related drugs.
- 11 **Other Stimulants**
- 12 **Benzodiazepines -** Includes Diazepam, Flurazepam, Chlordiazeposice, Clorazepate, Lorazepam, Alprazolam, Oxazepam, Temazepam, Prazepam, Riazolam, Clonazepam and Halazepam and other unspecified Benzodia zepine.
- 13 **Other Tranquilizers**
- 14 **Barbiturates:** This includes Phenobarbital, Seconal, Nembutal, etc.
- 15 **Other Sedatives or Hypnotics :** This includes Chloral Hydrate, Placidyl, Doriden, etc.
- 16 **Inhalants:** Includes ether, glue, chloroform, nitrous oxide, gasoline, paint thinner, etc.
- 17 **Over-the-Counter -** Includes aspirin, cough syrup, Sominex, and any other legally obtained, nonprescription medication.
- 18 **Other**

37-39. FREQUENCY OF USE OF DRUGS BY CLIENT (In last 30 days)

INSTRUCTIONS: Enter one of the following codes to indicate the frequency of use prior to admission for each substance recorded in Item 33-36.

IF CODE 00 NONE WAS ENTERED IN ITEMS 34 AND 35 FOR SECONDARY OR TERTIARY PROBLEM(S), ENTER CODE 00 IN THE CORRESPONDING BLOCK OF ITEMS FOR 38 AND 39. IF CODE 02 (NO) WAS ENTERED IN ITEM 36 (TOBACCO) ENTER CODE 00 IN THE CORRESPONDING BLOCK OF ITEM 40.

- 00 **Not applicable** (No substance in item (34-35). **(Cannot be used on #37)**)
- 02 **No past month use**
- 03 **Once in the last 30 days**
- 04 **2-3 days per month**
- 05 **Once per week**
- 06 **2-3 days per week**
- 07 **4-6 days per week**
- 08 **Once daily**

40. TOBACCO PRODUCTS ONLY (For use with question #40 only)

- 10 **About half a pack/can/pouch a day or less**
- 11 **About a pack/can/pouch a day**
- 12 **About a one and a half packs/cans/pouches a day**
- 13 **About 2 packs/cans/pouches a day**
- 14 **More than 2 packs/cans/pouches a day**

41-44. ROUTE OF ADMINISTRATION

INSTRUCTIONS: Enter route or method of use codes listed on the back of the TDS form and below as they apply to the primary, secondary and tertiary substance(s) recorded in Items 33-36. If more than one route or method of use exists, enter the most frequent route.

IF CODE 00 NONE WAS ENTERED IN ITEMS 34 AND 35 FOR SECONDARY OR TERTIARY PROBLEM(S), ENTER CODE 00 IN THE CORRESPONDING BLOCK OF ITEMS FOR 42 AND 43. IF CODE 02 (NO) WAS ENTERED IN ITEM 36 (TOBACCO) ENTER CODE 00 IN THE CORRESPONDING BLOCK OF ITEM 44.

CODES:

- 00 **Not Applicable** (No substance in Item 34-36). **(Cannot be used on #41)**
- 01 **Oral** (Swallowed, ingested or chewed)
- 02 **Smoking**
- 03 **Inhalation** (Snorted OR Sniffed)
- 04 **Injection** (IV or Intramuscular)
- 05 **Other**

45-48. **AGE OF FIRST USE**

Enter age of first use for the drugs identified in 33-36.

IF CODE 00 NONE WAS ENTERED IN ITEMS 34 AND 35 FOR SECONDARY OR TERTIARY PROBLEM(S), ENTER CODE 00 IN THE CORRESPONDING BLOCK OF ITEMS 46 and 47.

IF CODE 02 (NO) WAS ENTERED IN ITEM 36 (TOBACCO) ENTER CODE 00 IN THE CORRESPONDING BLOCK OF ITEM 44.

IF THE FREQUENCY OF USE OF THE PRIMARY SUBSTANCE IS 02 NO USE PAST MONTH, PLEASE ANSWER THE TWO QUESTIONS BELOW, OTHERWISE SKIP TO QUESTION 51.

49. **PLEASE INDICATE THE REASON THAT BEST DESCRIBES WHY THE CLIENT HAS NOT USED IN THE 30 DAYS PRIOR TO ADMISSION?**
(check ONE box only)

- ? 01 Recovery With Risk of Relapse
- ? 02 Client Reports No Problem
- ? 03 Self-Initiating Detoxification
- ? 04 Incarcerated/Institutionalized
- ? 05 Inpatient Treatment Program
- ? 06 OUI Client
- ? 07 Medication
- ? 99 Other

50. **WHEN DID THE CLIENT LAST USE ALCOHOL AND/OR OTHER DRUGS? (check ONE box only)**

- ? 01 In Last 3 Months
- ? 02 In Last 6 Months
- ? 03 In Last 12 Months
- ? 04 In Last 24 Months
- ? 05 In Last 5 Years
- ? 06 More Than 5 Years Ago

51. **INJECTION DRUG USE** (check ONE box only)

Check the box that reflects the client's injection drug use.

- ? 01 **Never**
- ? 02 **In Last 6 Months**
- ? 03 **In Last 5 Years**
- ? 04 **Prior to Last 5 Years**

NOTE: IF 01 NEVER, SKIP TO QUESTION #53

52. **SHARED NEEDLE USE** (check ONE box only)

If the client has used needles, did he/she share needles in the past year?

- ? 01 **Yes**
- ? 02 **No**

53. **USE OF METHADONE PLANNED AS PART OF TREATMENT?**
(check ONE box only)

Answer **Yes** if the client being served is/will receive methadone as part of his/her treatment at either your facility or at another facility.

- ? 01 **Yes**
- ? 02 **No**

54. **CURRENT LEGAL STATUS (Other than DEEP) (check ONE box only)**

This is for criminal actions. This does not refer to such things as divorce proceedings in the court system or minor traffic infractions.

- ? 00 **No legal involvement** - Client has no legal involvement at admission.
- ? 01 **Probation/Parole** - Client is on probation or parole at admission.
- ? 02 **Furloughed** - Client is in a furlough program.
- ? 03 **Awaiting court** - Client is currently awaiting trial.
- ? 04 **Serving sentence** - Client is currently serving his or her sentence in a correctional facility, **jail, prison**, etc.
- ? 05 **Formal Adjudication**
- ? 06 **Domestic Violence Offender** - Formal complaint lodged with criminal justice; may be under restraining order.
- ? 07 **Driver's License Revocation** (Not DEEP involved)
- ? 99 **Other** - Any legal status the client may have that is not affected in the other choices.

55. **TOTAL NUMBER OF ARRESTS IN THE LAST 12 MONTHS**

Enter the **total** number of times the client has been arrested (regardless of reason) in the last 12 months.

NOTE: INCLUDE OUI'S. – This number should be equal to or greater than the sum of #'s 56 and 57.

56. **SUBSTANCE ABUSE ARRESTS IN THE LAST TWELVE MONTHS**

Enter the number of times the client has been arrested for a substance related offense including such offenses as dealing drugs, or mugging for drug money in the last 12 months.

NOTE: DO NOT INCLUDE OUI'S

57. **OUI ARRESTS IN THE LAST TWELVE MONTHS**

Enter the number of times the client's been arrested for operating under the influence in the last 12 months.

NOTE: The totals of **56 + 57** should = **55**.

58. **WILL CLIENT USE TREATMENT TO SATISFY DEEP REQUIREMENTS?**
(check ONE box only)

If the client has an OUI, will he/she use this treatment to satisfy their DEEP requirements?

- ? 01 **Yes**
? 02 **No**

IF NO OR AFFECTED OTHER, GO TO QUESTION #60
If Client was DEEP referred, the answer must be 01 YES.

59. **DEEP STATUS (check ONE box only)**

Check the client's appropriate status. This information can/will be provided by the DEEP office.

- ? 01 **Non-Aggravated First Offender** - BAC .14 and below
? 02 **Aggravated First Offender** - BAC .15 and above, BAC .14 and below with an additional charge, or a refusal
? 03 **Multiple Offender** - Previous OUI
? 04 **.00 (Youthful) Offender** - Youthful offender at time of arrest

NOTE: If you did not answer # 58, skip # 59 and go to # 60.

60. **GLOBAL ASSESSMENT OF FUNCTIONING (GAF) SCALE.**

Enter the appropriate level of functioning based on the GAF scale.

See Appendix F.

61. **CLIENT AGREE TO A FOLLOW-UP?** (check ONE box only)

- ? 01 **Yes**
? 02 **No**

DATE FORM COMPLETED:(MO/DD/YEAR)

FORM COMPLETED BY:

FORM EDITED BY:
(Last Name/First)

PART 2

TDS FORM D-1

DISCHARGE FORM

INSTRUCTIONS

DETAILED INSTRUCTIONS FOR TDS D-1 DISCHARGE FORM

Upon discharge, the counselor must make a reassessment of the client. Except for items A through I, data from the TDS A-1 Admission Form cannot be copied onto the TDS D-1 Discharge Form.

The TDS D-1 Discharge Form is to be completed within thirty (30) days of the last client treatment contact date for all clients who have been admitted on the standard TDS A-1 Admission form - unless a reason for leaving the client file open is documented in the client file. No client file should remain open for as long as 90 days if the client is not receiving treatment.

NOTE: CLIENTS ADMITTED PRIOR TO OCTOBER 1, 1989 MUST NOT BE DISCHARGED ON THE D-1 DISCHARGE FORM. THE D-1 DISCHARGE FORM MUST ONLY BE COMPLETED FOR CLIENTS ADMITTED AND DISCHARGED ON OR AFTER OCTOBER 1, 1989.

AGENCY NAME

The name of the agency/provider **as it appears on license or certification**

?

?

? **Change/Correction**

Place a check in the box only if this form is being filled out as a change/correction. If it is a change/correction, please go to the change/correction section in your manual.

AGENCY TELEPHONE NUMBER

Telephone number of the agency.

CLIENT CODE

A. DATE OF BIRTH

Enter the client's birth date. Record MMDDYYYY. Precede numbers of less than 10 with a zero.

EXAMPLE: February 9, 1943 would be **02091943**.

B. LAST FOUR SOCIAL SECURITY NUMBERS

Enter the last four numbers of the client's social security number. If the client does not have a social security number then use **9999. 9999** should only be used after you have exhausted all means available to you to obtain their social security number.

EXAMPLE: John Smith's social security number is 005-23-9789: you would enter **9789**.

C. GENDER (check ONE box only)

- ? 01 **Male**
? 02 **Female**

D. COUNTY OF RESIDENCE

Enter the first and last letter of the County the client is residing in at admission. If "Out-of-State" use **OS**. If "Out-of-Country" use **OC**.

AN	Androscoggin	PT	Penobscot
AK	Aroostook	PS	Piscataquis
CD	Cumberland	SC	Sagadahoc
FN	Franklin	ST	Somerset
HK	Hancock	WO	Waldo
KC	Kennebec	WN	Washington
KX	Knox	YK	York
LN	Lincoln	OS	Out-of-State
OD	Oxford	OC	Out-of-Country

E. HOME TOWN/CITY (check ONE box only)

Size of home town/city at time of admission.

- ? 01 **URBAN I:** A town city of more than 10,000
? 02 **URBAN II:** A town city of 5,000 - 9,999
? 03 **RURAL:** A town of less than 5,000
? 04 **OS/OC:** Out-of-State, Out-of-Country (Required if D. was OS or OC)

See Appendix B for the listing of Urban I, Urban II, and Rural areas.

G. FEDERAL IDENTIFIER CODE

Enter the six digit numeric code provided by the federal government to the OSA. The code identifies the agency by physical location. If you do not have a federal identifier code listed in the appendices, please contact the TDS office as soon as possible.

Federal Identifier codes are listed in Appendix E

F. CONTRACT NUMBER (Funded Agencies Only)

If agency/provider has a contract with The Office of Substance Abuse, enter the contract number assigned. (If OSA is not an expected payor source, you do not need to enter the number.)

H. PRIMARY SERVICE CODES (List on back of form)

See specific explanations of primary service setting codes in **Appendix C**. This is the primary service you will provide for this client during the current admission.

NOTE: All agencies should use co-existing mental illness service settings for clients who have a co-existing mental illness.

All agencies delivering outpatient services should use 18 (Adolescent Outpatient) for all clients under 19 years of age who are receiving outpatient services.

**Substance Abuse/
Affected Clients**

**Substance Abuse Clients
Coexisting Mental Illnesses**

REHABILITATION/ RESIDENTIAL

03 Hospital (Other than Detoxification)	23 Hospital (Other than Detoxification)
04 Short-term (30 days or less)	24 Short-term (30 days or less)
05 Extended Care	25 Extended Care
06 Halfway House	26 Halfway House
07 Extended Shelter	27 Extended Shelter
15 Adolescent Res.	28 Adolescent Res.
Rehab.Transitional	Rehab.Transitional
44 Consumer Run Residence	45 Consumer Run Residence

Continued on Next Page

AMBULATORY

08 Non-Intensive Outpatient	29 Non-Intensive Outpatient
11 Intensive Outpatient	32 Intensive Outpatient
12 Detoxification	33 Detoxification
13 Evaluation	34 Evaluation
18 Adolescent Outpatient	35 Adolescent Outpatient
38 Adolescent Intensive Outpatient	39 Adolescent Intensive Outpatient
40 Methadone	

I. CURRENT ADMISSION DATE

The day the client is currently being admitted into treatment.

J. LAST FACE TO FACE CONTACT

The date of the last face to face contact with the client.

1. EMPLOYMENT STATUS (check ONE box only)

Check the self-reported current employment status at the time of discharge.
Employment refers to work in a paid (salary, wages, tips, etc.) position on a regular basis.

? 01 Full-Time (35 hours or more)

- A. Client who is working for pay at discharge and normally works 35 hours or more per week. This includes those who work at part-time jobs that total at least 35 or more hours per week; or
- B. Those persons temporarily absent from their regular jobs because of illness, vacation, industrial disputes (strikes), or similar reasons.

? 02 Part-Time (17-34 hours)

Client who is working for pay at discharge and normally works at least 17 hours but not more than 34 hours per week.

? 03 Irregular (less than 17 hours)

Client who is working for pay at discharge and normally works fewer than 17 hours per week.

CONTINUED ON NEXT PAGE

? 04 **Unemployed (has sought work)**

- A. Client who was not working at discharge but had sought work and was available within the preceding 30 days.
- B. Client who was not working at discharge, but was not working because they were on layoff, temporarily ill or waiting to start new jobs within the next 30 days.

? 05 **Unemployed (has not sought work)**

Client who is discouraged from seeking work because of personal or job market factors, and voluntarily idle.

? 06 **Not in Labor Force**

This refers to clients who are:

- A. Retired; or
- B. Engaged in their own housekeeping, not working while attending school (including adolescents), unable to work because of long-term illness.

THESE NEXT THREE CATEGORIES ARE DESIGNED FOR CLIENTS WHO ARE NOT CAPABLE OF HOLDING A PAYING POSITION SUCH AS DUAL DIAGNOSIS, LATE STAGE ALCOHOLICS, ETC.

? 07 **Full-Time Volunteer**

A client who volunteers at least 35 hours a week and does not receive monetary compensation for those hours.

? 08 **Part-Time Volunteer**

A client who volunteers at least 17 hours but not more than 34 hours a week and who does not receive monetary compensation for those hours.

? 09 **Irregular Volunteer**

A client who volunteers less than 17 hours a week and does not receive monetary compensation for those hours.

2. **EMPLOYABILITY FACTOR (check ONE box only)**

Check the appropriate factor listed below as it relates to the Employment Status.

- ? 01 - Employable or working now
- ? 02 - Student
- ? 03 - Homemaker
- ? 04 - Retired
- ? 05 - Unable (to work) physical or psychological reasons
- ? 06 - Inmate of Institution (Incarcerated)
- ? 07 - Seasonal Worker
- ? 08 - Temporary Layoff
- ? 09 - Unable (due to) skills/resources
- ? 10 - Unable (due to) program requirements

3. **IF THE CLIENT HAS LEGAL CUSTODY OF HIS/HER CHILDREN, WHERE WERE THE CLIENT'S CHILDREN WHILE THE CLIENT WAS IN TREATMENT? (Check ONE box only)**

If no dependents, skip # 3 and go to #4

- ? 01 With the Client
- ? 02 Spouse/Other Parent
- ? 03 Grandparents/Relatives
- ? 04 Friend(s)
- ? 05 Babysitter/Care Giver
- ? 06 Temporary Foster Care
- ? 99 Other

4. **MH/MR ISSUES: DIAGNOSIS BASED ON DSM-IV**

If the client has been diagnosed with a mental illness/disorder or mental retardation based on DSM-IV criteria, check 01 or 02, otherwise check NONE.

(Check ONE Box Only)

- ? 01 Diagnosed Mental Illness/Disorder
- ? 02 Mental Retardation
- ? 00 None

5. **HOW MANY PSYCHIATRIC ADMISSIONS TO A HOSPITAL DID THE CLIENT HAVE DURING TREATMENT?**

INSTRUCTIONS: Enter the number of psychiatric admissions the client had during treatment to any hospital.

6-8. **PRIMARY, SECONDARY AND TERTIARY DRUGS LISTED ON THE ADMISSION FORM.**

INSTRUCTIONS: Enter the same codes, in the same order, as listed on the client's A-1 admission form.

6. **Primary:**

Enter the code associated with substance identified at admission as the client's primary drug problem. This is the primary substance abuse problem for which the client was admitted to treatment.

THERE CAN BE ONLY ONE PRIMARY PROBLEM.

7. **Secondary:**

Enter the code associated with substance identified at admission as the client's secondary drug problem.

8. **Tertiary:**

Enter the code associated with substance identified at admission as the client's tertiary drug problem.

9. **TOBACCO (check ONE box only)**

- ? Yes
? No

NOTE: ITEM 9 (TOBACCO) , CHECK 01 (YES) OR 02 (NO) AS IT APPEARS ON THE ADMISSION FORM.

If client is Affected/Co-Dependent go to question 13.

10-12. **FREQUENCY OF USE OF DRUGS BY CLIENT (IN LAST 30 DAYS)**

INSTRUCTIONS: Enter one of the following codes to indicate the frequency of use in the last 30 days of treatment for **each substance** recorded in Items 6-9.

IF CODE 00 NONE WAS ENTERED IN ITEMS 7 AND 8 FOR SECONDARY OR TERTIARY PROBLEM(S), ENTER CODE 00 IN THE CORRESPONDING BLOCK OF ITEMS FOR 11 AND 12.

NONE (No substance listed in item 7-8). **(Cannot be used on #10)**

- 02 **No use past month**
- 03 **Once in the last 30 days**
- 04 **2-3 days per month**
- 05 **Once per week**
- 06 **2-3 days per week**
- 07 **4-6 days per week**
- 08 **Daily**

13. **TOBACCO PRODUCTS ONLY**

INSTRUCTIONS: Enter one of the following codes to indicate the frequency of use of tobacco in the last 30 days of treatment.

- 00 **NONE** (Only for someone who has never smoked)
- 09 **Not currently smoking** (Discharge Only)
- 10 **About half a pack/can/pouch a day or less**
- 11 **About a pack/can/pouch a day**
- 12 **About a one and a half packs/can/pouches a day**
- 13 **About 2 packs/cans/pouches a day**
- 14 **More than 2 packs/cans/ pouches a day**

EXAMPLE: If client answered **01** (YES) in item 9, Tobacco at admission; and upon discharge client is no longer smoking, item 9 will be the same as at admission; and item 13, frequency at discharge, would be **09** (NOT currently smoking.) If the client **NEVER** smoked, you would use the **00 NONE**.

14. **ASSISTANCE RECEIVED DURING TREATMENT.**

INSTRUCTIONS: Please check **YES** or **NO** for **each** item as to whether the client **did (01 Yes)** or **did not (02 No)** receive assistance with the services listed below during treatment.

These services were not necessarily delivered by your agency, but you some how aided the client in accessing these services.

YES	NO		YES	NO	
? 01	? 02	A. Medical Care	? 01	? 02	L. Drug and Alcohol Education
? 01	? 02	B. Prescription Medications	? 01	? 02	M. Financial Counseling
? 01	? 02	C. Acupuncture	? 01	? 02	N. Academic Services
? 01	? 02	D. Aversive Therapy	? 01	? 02	O. Vocational Services
? 01	? 02	E. Client Urine Testing	? 01	? 02	P. Legal Services
? 01	? 02	F. HIV Risk Reduction	? 01	? 02	Q. Tuberculosis Services
? 01	? 02	G. Child Care	? 01	? 02	R. Prenatal Care
? 01	? 02	H. Transportation to Treatment	? 01	? 02	S. Child/Counseling/Services
? 01	? 02	I. Employment/Counseling	? 01	? 02	T. Smoking Cessation Serv.
? 01	? 02	J. Crisis Intervention	? 01	? 02	U. Mental Health Services
? 01	? 02	K. Housing Assistance	? 01	? 02	Z. Other

NOTE: DO NOT LEAVE ANY ITEM BLANK.

15. **PARTICIPATED IN SCHOOL OR TRAINING WHILE IN TREATMENT**
(check ONE box only)

? 01 Yes
? 02 No

INSTRUCTIONS: Check **01 Yes** or **02 No** to indicate whether the client was/is currently enrolled in school (e.g., at any level) or in a formal training program (e.g., barber school, secretarial school, carpenter apprenticeship, JTPA training program), during treatment or at the time of discharge. Students who attended school in the spring and will be going back in the fall are still considered to be in school during the summer.

NOTE: OUI education classes or other educational programs operated by a provider or DEEP should not be considered enrolled in school or a training program. Check **02 No** if this is the only school or training the client is receiving.

16. **IS CLIENT CURRENTLY ATTENDING A SELF-HELP GROUP?**
(check ONE box only)

SELF HELP - Any non-therapeutic support that enhances the client's efforts in recovery. AA, NA, and AL Anon are the most common; however, any group or activity that promotes behavioral change facilitating sobriety/recovery is acceptable: church groups, retreats, social groups, etc.

Is client currently attending a substance abuse self-help support group.

- ? 01 **Yes**
? 02 **No**

17. **DID YOU RECOMMEND A SELF-HELP GROUP? (check ONE box only)**

SELF HELP - any non-therapeutic support that enhances the client's efforts in recovery. AA, NA, and AL Anon are the most common however any group or activity that promotes behavioral change facilitating sobriety/recovery is acceptable; it church groups, retreats, social groups, etc.

- ? 01 **Yes**
? 02 **No**

18. **"DELIBERATE" REFERRAL TO SUBSTANCE ABUSE SERVICES**
(check ONE box only)

INSTRUCTIONS: Place a check next to the appropriate service from the list to indicate the primary substance abuse service the client was referred to at discharge. Referral requires "deliberate action."

DEFINITION: "Deliberate Action" means your program has transported the client, written letters, made telephone calls to set up appointments, or taken similar action to see that the client actually is seen by the program you are referring to, a simple suggestion to a client to go somewhere for help is not considered a referral for the purpose of TDS.

LIST ON NEXT PAGE

- ? 00 None
- ? 01 Detoxification
- ? 02 Diagnosis & Evaluation
- ? 03 In Home Family Support
- ? 04 Extended Care
- ? 05 Extended Shelter
- ? 06 (Emergency) Shelter
- ? 07 Outpatient Counseling (general)
- ? 08 Intensive Outpatient
- ? 09 Residential Rehab (short-term)
- ? 10 Half and Quarterway House
- ? 11 Adolescent Res. Rehab Transitional
- ? 12 Substance Abuse Professional
- ? 13 Consumer Run Residence
- ? 99 Other

19. **IF REFERRED – REFERRED AGENCY CODE**

Enter the code established by the TDS office for the agency that the client has been referred to. The codes are listed in **Appendix D**. If the agency is not listed, contact the TDS office for a code.

NOTE: If **00** (None) is used in item #18, deliberate referral; **00** must be used in **19**.

20. **"DELIBERATE" REFERRAL TO OTHER THAN SUBSTANCE ABUSE TREATMENT**

Place a check next to **each** item listed to indicate whether the client **did (01 Yes)** or **did not (02 No)** get referred to the service.

- | YES | NO | |
|------|------|--|
| ? 01 | ? 02 | A. Mental Health Provider |
| ? 01 | ? 02 | B. Other Health Care Provider |
| ? 01 | ? 02 | C. Voc. Rehab/Job Replacement |
| ? 01 | ? 02 | D. HIV Antibody Counseling and Testing |
| ? 01 | ? 02 | E. School Counselor |
| ? 01 | ? 02 | Z. Other |

21. **ARRESTS**

TOTAL Number of times the client has been arrested **during treatment**.
(This must be greater than or equal to # 22)

22. **OUI ARRESTS DURING TREATMENT**

Number of times the client has been arrested for operating under the influence **during treatment**.

23. **HAS THE DEGREE OF PRESENTING PHYSICAL OR PSYCHOLOGICAL
DEPENDENCE ON THE ALCOHOL AND/OR OTHER DRUG
SUBSTANCE(S) IMPROVED AT DISCHARGE BASED ON
DOCUMENTATION IN THE CLIENT'S RECORD?**

(check ONE box only)

Clinical judgment will ultimately determine your response to this question.

NOTE: If the client is receiving an evaluation only, your response should be (02) **No**.

?

? 01 **Yes**

? 02 **No**

? 99 **Affected Other**

24. **GLOBAL ASSESSMENT OF FUNCTIONING (GAF) SCALE.**

Enter the appropriate level of functioning (at discharge) based on the GAF scale.

See Appendix F

25. STATUS AT DISCHARGE

Enter the status of the client at the time of discharge from the following codes (also listed on the back of the TDS form).

If you answer 30 (client left due to lack of child care) go to next question, otherwise skip to question #27.

- 01 Client termination (discharge) without clinic agreement
(i.e., client leaves without explanation).
- 02 Treatment is complete. *SEE DEFINITION BELOW*
- 03 Further treatment is not appropriate for client at this facility.
- 04 Non-compliance with rules and regulations.
- 05 Client refused service/treatment.
- 06 Unable to follow program requirements.
- 30 Client left treatment due to lack of childcare
- 07 Client discharged for medical and/or psychological Tx.
- 08 Client moved out of a catchment area.
- 09 Client cannot get to facility for further service/treatment.
- 10 Client cannot come for service/treatment during facility hours.
- 11 Client incarcerated.
- 12 Client deceased.
- 13 Parents/legal guardian withdrew client.
- 14 Termination due to program cut/reduction
- 15 Treatment completed for affected other/co-dependent.
- 16 Treatment not completed for affected other/co-dependent.
- 17 Evaluation only.

NOTE: ONLY USE CODES 15, 16, and 17 FOR THE AFFECTED OTHER/CO-DEPENDENT.

Completion of Treatment is Defined as:

Client achieves at least 2/3 of his/her most current agreed upon treatment plan and the clinician is in agreement with the discharge. The plan should include objectives specific to client need and might include the following:

- ? Abstinent 30 days prior to discharge
- ? Significant reduction in problematic use
- ? Willingness to voluntarily seek continuing care as necessary
- ? Participation in self-help

26. **IF CLIENT LEFT DUE TO LACK OF CHILD CARE, WHAT WAS THE REASON?** (Only answer if question 25 was 30)

Place a check next to the reason that best describes why the client had problems attaining/maintaining child care while they were in treatment.

(Check ONE box only)

- ? 01 Accessibility
- ? 02 Money/Cost
- ? 03 Length of stay/treatment
- ? 99 Other

27. **PRIMARY EXPECTED SOURCE OF PAYMENT**

Enter the code for the primary funds or reimbursement you expect to receive for services you anticipate will be provided to the client. This includes State contract/grant sources e.g., OSA, DOC, and DHS.

NOTE: If 01 Office of Substance Abuse is indicated, a contract number **must** be entered into *F*, at the top of the form.

- 00 None (can not use on #27 Primary)
- 01 OSA Office of Substance Abuse (DMH/MRSAS)
- 02 Human Services (Other than Child, Adult Protective)
- 03 Corrections
- 04 Human Services (Child, Adult Protective)
- 05 Self-pay
- 06 Medicaid
- 07 Medicare
- 08 Blue Cross/Blue Shield
- 09 Health Maintenance Organization (HMO)
- 10 Other Private Health Insurance
- 11 Town Assistance
- 12 Workers' Compensation
- 13 Veteran's Administration
- 14 Other

28. SECONDARY EXPECTED SOURCE OF PAYMENT

(If different than Primary Source)

Enter the code for the secondary funds or reimbursement you expect to receive for services you anticipate will be provided to the client. This includes State contract/grant sources. e.g., OSA, DOC, and DHS.

- 00 **None** (for use with Secondary and Tertiary only)
- 01 **OSA** Office of Substance Abuse (DMH/MRSAS)
- 02 **Human Services** (Other than Child, Adult Protective)
- 03 **Corrections**
- 04 **Human Services** (Child, Adult Protective)
- 05 **Self-pay**
- 06 **Medicaid**
- 07 **Medicare**
- 08 **Blue Cross/Blue Shield**
- 09 **Health Maintenance Organization** (HMO)
- 10 **Other Private Health Insurance**
- 11 **Town Assistance**
- 12 **Workers' Compensation**
- 13 **Veteran's Administration**
- 14 **Other**

29. **TERTIARY EXPECTED SOURCE OF PAYMENT**

(If different than Primary and/or Secondary Source)

Enter the code of the tertiary funds or reimbursement you expect to receive for services you anticipate will be provided to the client. This includes State contract/grant sources e.g., OSA, DOC, and DHS.

- 00 **None** (can only be used for Secondary and Tertiary)
- 01 **OSA Office of Substance Abuse (DMH/MRSAS)**
- 02 **Human Services** (Other than Child, Adult Protective)
- 03 **Corrections**
- 04 **Human Services** (Child, Adult Protective)
- 05 **Self-pay**
- 06 **Medicaid**
- 07 **Medicare**
- 08 **Blue Cross/Blue Shield**
- 09 **Health Maintenance Organization (HMO)**
- 10 **Other Private Health Insurance**
- 11 **Town Assistance**
- 12 **Workers' Compensation**
- 13 **Veteran's Administration**
- 14 **Other**

30. **TOTAL NUMBER OF UNITS AND COST PER UNIT (list on back of form)**

Enter the code(s) associated with the services(s) provided to the client, the number of units delivered to the client, and the cost per unit. The cost per unit should be the amount in the agency's contract with the State of Maine. If the agency does not have a contract with the State of Maine, please use the agency or provider normal cost per unit regardless of the charge to the client.

Codes:

REHABILITATION/RESIDENTIAL

- 03 Hospital
- 04 Short-Term Res/Rehab
- 05 Extended Care
- 06 Halfway House
- 07 Extended Shelter
- 11 Consumer Run Residence
- 21 Res. Rehab. Adolescent Transitional (**Ambulatory – next page**)

AMBULATORY

08	Individual
09	Family
10	Group
13	Intensive Outpatient
15	Evaluation
16	Methadone Dispensing

Units:

Individual, group, and family units need to be reported in 15 minute increments.

Intensive outpatient units need be reported in daily increments.

EXAMPLE: John had weekly sessions with a counselor and attended group once a week as well for four months. John's units would be as follows:

<u>Code</u>	<u>Units</u>	<u>Cost</u>
08	0064	017.81
10	0064	006.25

Cost Per Unit: *As set by Agency with certain guidelines and/or restrictions*

DATE FORM COMPLETED:

FORM COMPLETED BY:

This form is to be signed by interviewer. **THIS FIELD MUST BE ENTERED.**

FORM EDITED BY:

All forms are to be edited for accuracy and completeness. To be signed by person editing completed forms. This may be the same person who filled out the forms originally.

Mail the OSA copy of the completed TDS Forms to:

TDS Office

Office of Substance Abuse

Marquardt Building

AMHI Complex 3rd Floor

#159 State House Station

Augusta, Maine 04333-0159

F.

*** A copy of the TDS form should be retained in the client file (from the multi-part forms, retain the “Agency Copy”)**

PART 3

Changes / Corrections

To The

TDS Forms

CORRECTIONS TO THE TDS FORMS

If your agency has a correction to make to a TDS form that has already been sent to the TDS office, the Corrections can be made in one of two ways:

*Make a photo copy of the form to be corrected. Using a **RED** pen, check off CHANGE/CORRECTION in the box on the top of the page. Then make the correction, also using the RED pen. The correction must be legible.

*Using a blank form, check off CHANGE/CORRECTION in the box on the top of the page. Copy items **A through L** from the form to be corrected. Then fill out only the items to correct. If the change is to an **A through L** item, circle the change too—with a RED pen.

The changes/corrections must be done on the same type of form being corrected. In other words, if the correction is to the A-1 Admission form, the correction must be made on an A-1 form (blue). If the correction is being made to a D-1 Discharge form, the correction must be made on a D-1 form (yellow). If the correction is being made to the A-D form, the correction must be made on the A-D form (pink).

PART 4

90 DAY CASE PLAN FORM

90 DAY CASE PLAN REPORT

OSA will forward to the substance abuse agency's designated contact person a computer print-out of this form with:

1. The client's ID, birthdate, and date of admission preprinted by the TDS computer system. These will be in numerical order.
2. Please fill out the provider unit, telephone, and agency person as appropriate.

The service provider will also complete the following sections: Client's Last Face-to-Face Treatment Date and the Comments area.

1. The service providers must have a system in place to easily identify the client.
2. If the service agency is unable to match a client's ID with their records (name list), they are to contact the OSA.
3. The Last Face-to-Face Treatment Date should be completed for all clients. If the Last Face-to-Face Treatment Date is more than 30 days prior to receiving the 90 Day Case Plan Report:

The client should be discharged unless a specifically noted reason is in the client's record. The reason noted in the file should be noted under Comments on the 90 Day Case Plan Report.

If a reason is not noted in the client record, the client should be discharged and "Discharged" entered in the Comments area of the 90 Day Case Plan next to the appropriate client ID

If the client has had a Last Face-to-Face Treatment Date within the last 30 days:

1. Enter the date and leave the Comments area blank.

THE COMPLETED 90 DAY CASE PLAN REPORT MUST BE MAILED BACK TO THE TDS OFFICE WITHIN 10 WORKING DAYS FROM THE DATE THE AGENCY RECEIVES THE REPORT.

PART 5

FOLLOW-UP IDENTIFICATION FORM

FOLLOW-UP REPORT

OSA or the contracted third-party agency will forward to the provider unit (those who served the client) a computer print-out of this form with:

1. The heading and numbers 1-3 are completed by TDS.
2. The client's ID and date of admission and last treatment date will also be completed by TDS. They will be in numerical order.

The service provider will complete the client's name, address and telephone number of the Follow-up Report.

1. The service providers must have a system in place to easily provide a client's name, address and telephone number when given only the client's ID for follow-up.
2. If the service agency is unable to match a client's ID with their records (name list), they are to contact the OSA.
3. The Follow-up Report is to be completed and forwarded to the follow-up contract agency by the provider unit within 7 working days after it is received from the OSA.

The follow-up interview contract agency will transfer the appropriate information from this form to the Follow-up Interview Form. The remaining information is obtained during the interview.

1. The client's name will not be transferred to the Follow-up Interview Form.
2. If there are problems with the information obtained from the service agency, the contract agency will contact the service agency individual responsible for completing the form.
3. If there are problems with the interviewing process, the contract agency will contact the OSA.

APPENDIX A

Attorney General's Opinion

(Attorney General's Opinion Page is not available electronically.)

APPENDIX B
Urban I, Urban II, and Rural Codes

POPULATION CONCENTRATIONS - 1987 POPULATIONS

4 Levels	Urban 1:	10,000 and above
	Urban 2:	5,000 - 9,999
	Rural:	Less than 5,000
	OS/OC:	Out-of-State / Out-of-Country

Urban 1 and Urban 2 Lists Only

Androscoggin

Auburn	Urban 1
Lewiston	Urban 1

Aroostook

Caribou	Urban 2
Houlton	Urban 2
Limestone	Urban 1
Presque Isle	Urban 1

Cumberland

Brunswick	Urban 1
Cape Elizabeth	Urban 1
Portland/Falmouth	Urban 1
Freeport	Urban 2
Gorham	Urban 1
Gray	Urban 2
Scarboro	Urban 1
So. Portland	Urban 1
Standish	Urban 2
Westbrook	Urban 1
Windham	Urban 1
Yarmouth	Urban 2

Franklin

Farmington	Urban 2
Jay	Urban 2

Hancock

Ellsworth	Urban 2
-----------	---------

Oxford

Rumford	Urban 2
Norway/Lisbon	Urban 2

Penobscot

Bangor/Brewer	Urban 1
Lincoln	Urban 2
Hampden	Urban 2
Millinocket	Urban 2
Old Town	Urban 2
Orono	Urban 2

Piscataquis

All rural

Sagadahoc

Bath	Urban 1
Topsham	Urban 2

Somerset

Fairfield	Urban 2
Skowhegan	Urban 2

Waldo

Belfast	Urban 2
---------	---------

Washington

All rural

Kennebec

Augusta/Hallowell	Urban 1
Gardiner	Urban 2
Oakland	Urban 2
Waterville	Urban 1
Winslow	Urban 2
Winthrop	Urban 2

Knox

Rockland	Urban 2
----------	---------

Lincoln

All rural

York

Berwick	Urban 2
Biddeford	Urban 1
Buxton	Urban 2
Eliot	Urban 2
Kennebunk	Urban 2
Kittery	Urban 2
Old Orchard Beach	Urban 2
Saco	Urban 1
Sanford	Urban 1
So. Berwick	Urban 1
Waterboro	Urban 2
Wells York	Urban 2
York	Urban 2

UNLESS NOTED ABOVE, ALL OTHER TOWNS ARE RURAL

APPENDIX C
Service Definitions

SERVICE SETTING DEFINITIONS

DETOXIFICATION

1. Medical Model - Hospital Inpatient

Detoxification - Medical Model is a component which provides persons having acute problems related to withdrawal from alcohol or other drugs with immediate assessment, diagnosis and medically assisted detoxification, as well as appropriate referral and transportation for continuing treatment. The program shall provide services on a 24-hour per day basis.

RESIDENTIAL REHABILITATION (30 days or less)

Residential Rehabilitation is a component which provides substance abuse treatment services in a full (24 hours) residential setting. The Residential Rehabilitation component shall provide a scheduled program which consists of diagnostic, educational, and counseling services; and treatment shall refer clients to support services as needed.

EXTENDED CARE

Extended care is a component which provides a long-term supportive environment for individuals with serious and extensive problems resulting from A+D abuse. The Extended Care Component requires sustained abstinence and provides minimal treatment and ongoing living experience within the facility/program or re-entry into the treatment system. The term of residency is usually in excess of 180 days.

HALFWAY HOUSE

A Halfway House is a community-based, peer-oriented residential program that provides treatment and supportive services in a chemical free environment for persons involved in a recovery process. Programs are varied in character each designed to relate to the target group served, taking into consideration the needs of the individual. Thus, the Halfway House shall address the cultural, social, and vocational needs of the clients it serves. The program will provide transitional assistance in bridging the gap between the A+D use and recovery.

SERVICE SETTING DEFINITIONS (Continued)

EXTENDED SHELTER

Extended shelter is a component which provides a structured treatment environment for clients who are in a waiting list for treatment, or who have completed a detoxification program, and who need a social support system in order to provide continuity of treatment of substance abuse problem, and/or to enable the client to develop an appropriate supportive environment in order to maintain sobriety and to develop linkages with community services.

ADOLESCENT RESIDENTIAL REHABILITATION

Provides recovery through a "therapeutic community" model which emphasizes personal growth through family and group support and interaction. Therapy focuses on attitudes, skills, and habits, conducive to facilitating the recipient's transition back to the family and community.

OUTPATIENT - Non-Intensive (General Outpatient)

Outpatient Care is a component which provides assessment, and treatment services. These services may also be provided to the affected others whether or not the primary abuser is receiving treatment.

INTENSIVE OUTPATIENT

Intensive Outpatient is a component which provides an intensive and structured program of substance abuse assessment, diagnosis and treatment services in a setting which does not include an overnight stay. The program includes a structured sequence of multi-hour clinical and educational sessions scheduled for three or more per week, with a minimum of nine hours per week per client.

DETOXIFICATION - Ambulatory

Outpatient treatment services providing for safe withdrawal in an ambulatory setting (pharmacological or non-pharmacological).

EVALUATION

Systematic clinical process intended to determine the status of a clients' substance use/abuse. To then assess his/her need for treatment and when treatment is indicated to outline the

modality of treatment. The term "diagnosis" refers to medical diagnosis, and "evaluation" to educational, social, psychological, etc., evaluations performed by licenses/recognized individuals within the profession.

SERVICE SETTING DEFINITIONS (Continued)

SHELTER

Shelter is a service which provides food, lodging, and clothing for abusers of alcohol and other drugs, with the purpose of protecting and maintaining life and motivating them to seek substance abuse treatment. Shelter is a pre-treatment service usually operated in connection with a Detoxification component. At a minimum, will be available 24 hours per day.

OUI

Weekend Intervention Program

Non-aggravated First Offender Assessment

Teen Offender

APPENDIX D
REFERRED AGENCY CODES

None	00	Dumas, Greg – Saco Bay Cnseling	G1
Abbak	L4	Eagle Lake Health Center	18
Acadia Family Center	88	East Grand Health Clinic, AMHC	73
Acadia Health, Inc (Options)	02	Eastport Health Center	20
Acadia Recovery Community	24	Easy Does It House	J7
ACCESS	I6	Evergreen (Franklin Mem.Hospital)	E8
Alternate Choice's Cnslng Srvc	89	Evodia House	32
Alternative Counseling Service	90	Facing Change	86
Aroostook Mental Health Center	05	Family Intervention Services	J2
Augusta Mental Health Institute	03	Families United	70
Bangor Mental Health Institute	07	Fellowship House	21
Bangor Pre-Release Center	K5	Food Add. & Chem. Dep.	H4
Bean, Michael	M7	Friendship House	G3
Begin Again, Inc.	M8	Fusco, Tom	H7
Boyer, Susan	94	Gateway	78
Calais Regional Hospital	97	Gigure, John	K9
Camel Club	F2	Goodrich, Elaine	B1
Casco Bay Substance Abuse	A1	Grace House	K4
Cathance Psychological Services	M9	Hayden, William (Crest Counseling)	B3
Catholic Charities ME/Counsel Svcs	09	Haven House	46
CDRP - Bangor	I4	Healthreach/Hearthside	23
Central Me. Indian Assoc. (CMIA)	11	Healthreach/New Directions	39
Central Maine Counseling Services	71	Health Care for Portland	
Choice/Skyward	10	(Homeless Project)	80
Common Ties	L9	Helmstadter, John & Pam	J4
Community Concepts	J5	Hite, George	B4
Community Health and Counseling	12	Houlton Band of Maliseets	25
Conner, Pat	A3	Iannotti, Dominick	M3
Coose, Chris	N5	Ingraham/Mainstay	M5
Cornerstone	17	Ingraham/Randall Place	N8
Counseling Services, Inc.	06	Ingraham/The Bridge	N9
Crisis and Counseling	13	Integral Therapy	72
Crossroads for Women	14	Institute of Spontaneity	82
Danley, Colleen	N6	Jackson Brook Institute	26
Day One (James Harrod Center)	F7	Jails (if not listed elsewhere)	H6
Day One (Maine Youth Center)	F8	James, Timothy	B6
Day One Outpatient	15	Janus House	E9
Dayowl	L2	JNF Counseling Associates	B8
Dearborn-Corson, Donna	P1	Jordan House	F6
DEEP	16	Katahdin Valley Health Center	27
(For clients who have had an evaluation but don't choose an agency upon discharge from the evaluation)		Kelly, Karen	G7
Discovery House of Central ME	49	Kennebec Valley Mental Hlth	K7
Discovery House of Maine	I3	Kimball, Kerry	C1
		Lawrence, Suzanne	C3
		Limestone	49

Lubec, Regional Medical Center at	48	Rural Family Counseling	L5
Lutheran Family Services	29	Searsport Counseling	M1
Lyon, Katharine	Q4	Sebasticook Hospital	53
Maine Coast Memorial Hospital	30	Serenity House	54
Maine Counseling Associates	79	Sign of Hope /Bangor	M4
Maine Correctional Center	31	Spring Harbor	S1
Maine General Med Ctr/Serene	Q5	St. Regis Mohawk Center	51
Maine General / Spruce St Res.	Q6	St. Mary's Hospital	50
Maine State Prison	75	St. Francis House	T5
Mayo Regional Hospital	33	St. Andres	G4
McCullough, Ken – Aug Grp Wlnes	C7	Steppingstone/McWalters, Tom	E2
McKenney, Gary	D1	Substance Abuse Svcs of Ellsworth S2	
Mclean, George	Q7	Thacher, Sarah	H9
Megeachy Hall - MMC	J1	Tingley, Charles	E4
Mercy Hospital	34	Togus VA Hospital	57
Mid-Coast Hospital / ARC	01	Transitions	L7
MidCoast Mental Health Center	I5	Tri-County Mental Health Center	58
MidCoast Sub. Abuse Council	L3	Unity Reg. Youth Treatment Ctr	59
Mid-Maine Medical Center(Seton)	35	UMO (Substance Abuse Svcs)	H3
Milestone – Old Orchard Beach	P8	Veteran's Center of Bangor	H8
Milestone - Portland	37	Veteran's Center of Lewiston	G6
Millinocket Regional Hospital	69	Veteran's Center of Portland	F3
Mt. Desert Island Hospital	38	Wabanaki Mental Health	L8
New England Counseling Assoc.	F9	Waldo Cty General Hospital	77
Northeast Care	40	Wellness Health Association	I1
Northeast Occupational Exchange	Q9	Wellspring	60
Nova Counseling Services	R1	Westbay	H5
Open Door	41	Westbrook Community Hospital	61
Out of State Facility	42	Witman, Dulcie	K2
Outpatient Chemical Dep.	D4	Wolph-Johnson, Maxine	S6
Oxford House (3-1/4 way house)	43	York Hospital	65
Passamaquoddy Indian Township	44	York County Shelter	64
Penobscot Indian Nation	45	YWCA Intervention Program	M6
Penobscot Valley Hospital	D6	YWCA - Park St. Portland	S7
PenBay Med Ctr / Choice Skyward	K1	YWCA – Spring St. Portland	53
Pepin, Gerard	R6	Your Choice	H1
Pharos House	J9	Youth and Family Services	66
Preble Street Resource Ctr	K3		
Private Practitioner (Other)	47		
PROP-Women's Program	L1		
Recovery Counseling Services	D7		
Rice, Ted	D9		
Riverside Comm. Ctr. (Rose Kocur)	C2		
Rothrock, Vivian	R7		
Rumford Community Hospital	E1		

APPENDIX E

**Federal Identification Codes For
Contracted Substance Abuse Provider Agencies**

and

DEEP Community Service Private Practitioners

Acadia Health Care Bangor/BMHI		102247
Acadia Recovery Community (Hospital)		
Bath		100043
Pittsfield (Sebasticook)		101561
Bangor		103922
Alternate Choices		
Rockland		102072
Vinalhaven		103641
Waldoboro		101355
Aroostook Mental Health Center		
Ashland		100076
Caribou		900434
Danforth		100803
Eagle Lake		100787
Fort Kent		900459
Houlton		900467
Limestone		900483
Madawaska		900491
Patten		100795
Presque Isle		900541
Van Buren		301237
Cathance Psychological Services		
Machiasport (Downeast Correctional)		102353
Catholic Charities /Fellowship House	Lewiston	750151
/St. Francis	Auburn	100688
Catholic Charities Maine/Counseling Services		
Falmouth		105133
Portland		750359
Common Ties (Area IV Dual Diagnosis Cooperative)		
Lewiston		102494
Community Concepts		
Auburn		102536
Oxford high school		103542
Rumford		102544
South Paris		102478

Counseling Services, Inc.	
Kezar Falls	100753
Kittery	100746
31 Beach Street, Saco	100738
Sanford	100761
Lincoln Street, Saco	301203
Crisis & Counseling	
Augusta	100019
Crossroads for Women	
Windham	750292
Portland	103260
Day One / Drug Rehabilitation – including Juvenile Justice Network	
Cape Elizabeth	105141
Bar Mills (JCH)	301104
Portland	301229
South Portland (MYC)	100910
Healthreach/Hearthside	
Sidney	100498
Health Reach Network/New Directions	
Albion	100647
Augusta, Weston St.	900400
Augusta, Vickery Bldg.	102577
Bingham	100571
Coopers Mills	100589
Farmington	100597
Gardiner	100852
Hartland	100555
Kingfield	100613
Leeds	100639
Livermore Falls	100605
Madison	100530
Thorndike (Mt. View High School)	102221
Readfield	102551
Richmond	100563
Skowhegan	100548
Strong	100621
Waterville	100522
Winthrop	102569

Lubec, Regional Medical Center at	
Calais	105166
Eastport	100670
Lubec	100662
Machias	
Maine Counseling Services (Association)	
Charleston	100902
Maine General Medical Center	
Augusta (Spruce St. Residence)	102304
Waterville (Serene)	750326
Maine Medical Center – ACCESS	
Portland	102262
Mayo Regional Hospital	
Dover-Foxcroft	750110
MidCoast Hospital/ (ARC) Addiction Resource Center	
Bath	102031
Lincoln	103690
MidCoast Mental Health Center	
Belfast	105158
Rockland	102460
MidCoast Substance Abuse Council	
Camden	102452
Milestone Foundation, Inc.	
Old Orchard Beach	750227
Portland	103609
Mount Desert Island Hospital	
Bar Harbor	750052
Open Door Recovery Center	
Ellsworth	900848
PenBay Medical Center/ Choice Skyward	
Rockport	103526
Rockland	102619
Vinalhaven	104870

PROP - Womens Project	
Bangor	103948
Portland	102486
Portland, City of	
Portland	103567
Serenity House	
Portland	750250
Tri-County Mental Health Services	
Auburn	100696
Bethel	100142
Bridgton	101983
Farmington	900855
Lewiston, Lisbon Street	750177
Lewiston,Pine Street	100704
Rumford	750391
South Paris	900608
Wabanaki Mental Health Association	
Bangor	102817
Brewer	104409
Waldo County General Hospital, Coastal Counseling Services	
Belfast	100290
Wellspring, Inc.	
Bangor, 98 Cumberland Street	750029
Bangor, 319 State Street	900665
Bangor, 251 Broadway	100340
York County Shelters, Inc	
Alfred	900764
York Hospital – Cottage Program	
York	100175
Youth & Family Services, Inc.	
Pittsfield	100712
Skowhegan	900657

Driver Education and Evaluation Program

**Community Service Providers
Federal Identification Codes**

ABBAK	
Bangor	101520
Dover Foxcroft	103518
Newport	104045
Skowhegan	103997
Acadia Family Center	
Southwest Harbor	101173
Alternative Counseling Services	
Bangor	101454
Augusta Group for Wellness – Ken McCullough	
Augusta	104961
Bean, Michael W.	
Kennebunk	104318
Portland	104086
Begin Again, Inc	
Presque Isle	104060
Casco Bay Substance Abuse Resource Center	
Portland	101090
Central Maine Counseling Services, Inc	
Lewiston	100092
Rumford	101389
South Paris	101371
Conner, Patricia	
Brunswick	101140
Coose, Christopher	
Portland	103666
Danley, Colleen	
Bridgton	102676
Dayowl Counseling	
Saco	102874
Dearborn-Corson, Donna	
Skowhegan	105224

DEEP ADULT	Auburn	999990
DEEP ADULT	Augusta	999991
DEEP ADULT	Bangor	999992
DEEP ADULT	Bath	999921
DEEP ADULT	Belfast	999928
DEEP ADULT	Biddeford	999916
DEEP ADULT	Brunswick	999931
DEEP ADULT	Calais	999932
DEEP ADULT	Damariscotta	999933
DEEP ADULT	Dover-Foxcroft	999922
DEEP ADULT	Ellsworth	999929
DEEP ADULT	Farmington	999925
DEEP ADULT	Gorham	999994
DEEP ADULT	Greenville	999934
DEEP ADULT	Houlton	999930
DEEP ADULT	Lincoln	999935
DEEP ADULT	Machias	999923
DEEP ADULT	Millinocket	999924
DEEP ADULT	Newport	999926
DEEP ADULT	Portland	999915
DEEP ADULT	Presque Isle	999993
DEEP ADULT	Rockland	999918
DEEP ADULT	Rumford	999920
DEEP ADULT	Sanford	999917
DEEP ADULT	Skowhegan	999927
DEEP ADULT	Waterville	999919

DEEP TEEN	Auburn	999901
DEEP TEEN	Augusta	999902
DEEP TEEN	Bangor	999903
DEEP TEEN	Houlton	999904
DEEP TEEN	Machias	999905
DEEP TEEN	Madawaska	999906
DEEP TEEN	Portland	999907
DEEP TEEN	Presque Isle	999908
DEEP TEEN	Rockland	999909
DEEP TEEN	Sanford	999910
DEEP TEEN	Skowhegan	999911
DEEP TEEN	South Paris	999912
DEEP TEEN	Topsham	999913
DEEP TEEN	Waterville	999914

Dumas, Greg /Saco Bay Counseling
Saco

101843

Evergreen Behavioral Services	
Farmington Franklin Memorial Hospital	101892
Livermore Falls	105208
Facing Change	
Lewiston	100944
Family Intervention Counseling Services	
Lewiston	102833
Auburn	
Ferguson, Ralph	
Newcastle	103930
Food Addiction & Chemical Dependency Consultants.	
Portland	102056
Windham	104979
Fusco, Tom	
Bath	101751
Gateway Recovery	
Norway	104029
Hasson, Donna	
Biddeford	104052
Hayden, William/Crest Counseling Services	
Auburn	100993
Helmstadter, John, LSAC	
Damariscotta	101918
Edgecomb	101926
Helmstadter, Pam	
Damariscotta	103252
Edgecomb	103245
Iannotti, Dominick J.	
Lewiston	103674

James, Timothy	
Bangor	103971
Dover Foxcroft	104037
Newport	104011
Skowhegan	104003
Kelly, Karen	
Belfast	101835
Kennebec Valley Mental Health Center	
Augusta	102361
Waterville	102379
Lawrence, Suzanne	
Bar Harbor	105174
Bucksport	101181
Deer Isle	105182
Ellsworth	101215
McCullough, Ken – Augusta Group for Wellness	
Augusta	104961
McKenney, Gary W., LSAC	
Portland	101041
McLean, George	
Lisbon Falls	102775
Mercy Hospital, Recovery Center	
Portland (State Street)	900715
(Forest Ave.)	103955
New England Counseling Services	
Mexico	101959
Nova Counseling Services	
Bangor	104854
Olivares, Susan	
Pittsfield	104987

Outpatient Chemical Dependency	
Bangor	101504
Ellsworth	101207
Machias	103989
Paul, William	
Houlton	103617
Penobscot Nation Counseling Services-Native Americans Only	
Old Town (Health Department)	900509
Riverside Community Center (Rose Kocur)	
Lincoln	101629
Rothrock, Vivian	
Buxton	103914
Rumford Community Hospital	
Rumford	100316
Rural Family Counseling	
Lincoln	102197
Millinocket	102205
Orono	105125
Searsport Counseling Associates	
Searsport	102726
Swanville	104888
Sign of Hope Counseling Associates	
Lincoln	103534
Southwestern Maine Clinical Associates/Sub Abuse & Addiction Services	
Gorham	101066
Spring Harbor	
Scarborough	104953
St. Mary's Regional Medical Center	
Gray Counseling Center	105190
Lewiston	900632
Mexico Counseling Center	105216

Substance Abuse Services of Ellsworth Ellsworth	103633
Tingley, Charles O., Jr. Bangor	101405
Transitions Counseling, Inc.	
Auburn 1441 Hotel Rd	
Lewiston 105 Middle	104177
Portland 158 Danforth	103484
Portland 178 Middle	104144
Portland 19 South St	104938
Portland 20-36 Danforth	104128
Portland 222 Auburn St	104110
Portland 222 St. John St	103500
Portland 32 Pleasant	104151
Portland 491 Stevens Ave	102601
Portland 535 Ocean	104748
Portland 59 Middle	104136
Saco 100 King St	104102
Saco 5 Horton	103450
Yarmouth 261 Main	104185
Wellness Health Associates, Inc.	
Augusta	102882
Brunswick	103963
Portland	102866
West Bay Counseling Services	
Belfast	102114
Starks	104896
Unity	104433
Waterville	104441
Westbrook Community Hospital Westbrook	100167
Wolph-Johnson, Maxine	
Farmington	
Starks	105232

APPENDIX F

Global Assessment

Assessment of

Functioning (GAF)

Scale

Global Assessment of Functioning (GAF) Scale

The GAF Scale reports the clinician's judgment of the individual's overall level of functioning and is useful in tracking the clinical progress of individuals on global terms, using a single measure. The GAF Scale measures only psychological, social, and occupational functioning. Do not include impairment due to physical or environmental limitations. Rating for TDS should reflect current functioning, i.e., at time of admission and at time of discharge. The GAF is AXIS V of the DSM-IV multi-axial classification.

Code: (Note; Use intermediate codes when appropriate. E.g., 45, 68, 72)

100 ? 91	Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many positive qualities. No symptoms.
90 ? 81	Absent or minimal symptoms (e.g., mild anxiety before an exam), good functioning in all areas, interest and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns (e.g., an occasional argument with family members).
80 ? 71	If symptoms are present, they are transient and expectable reactions to psychosocial stressors (e.g., difficulty concentrating after family argument); no more than slight impairment in social, occupational, or school functioning (e.g., temporarily falling behind in school work).
70 ? 61	Some mild symptoms (e.g., depressed mood and mild insomnia) OR some difficulty in social, occupational, or school functioning (e.g., occasional truancy, or theft within the household), but generally functioning pretty well, has some meaningful interpersonal relationships.
60 ? 51	Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).
50 ? 41	Serious symptoms (e.g., suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational, or school functioning (e.g., no friends, unable to keep a job).
40 ? ? 31	Some impairment in reality testing or communication (e.g., speech is at times illogical, obscure, or irrelevant) OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood (e.g., depressed man avoids friends, neglects family, and is unable to work; child frequently beats up younger children, is defiant at home, and is failing at school).
30 ? ? 21	Behavior is considerably influenced by delusion or hallucinations OR serious impairment in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day, no job, home, or friends).
20 ? 11	Some danger of hurting self or others (e.g., suicide attempts without clear expectation of death; frequently violent; manic excitement) OR occasionally fails to maintain minimal personal hygiene (e.g., smears feces) OR gross impairment in communication (e.g., largely incoherent or mute).
10 ? 1	Persistent danger of severely hurting self or others (e.g., recurrent violence) OR persistent inability to maintain minimal personal hygiene OR serious suicidal act with clear expectation of death.
0	Inadequate information.

Reprinted with permission from the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Copyright 1994 American Psychiatric Association.